CLINICAL APPLICATION OF CULTURAL ELEMENTS

For Hispanic and Latino Populations

National Hispanic & Latino

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

PO Box 60327
Bayamón, Puerto Rico 00960-6032

This publication was prepared by the National Hispanic and Latino Addiction Technology Transfer Center (NHLATTC) under a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). All material appearing in this publication is of domain of the National Hispanic and Latino Addiction Technology Transfer Center (NHLATTC) and cannot be reproduced, copied or distributed without permission for a fee without specific, written authorization from the NHLATTC. Copies may be ordered from the NHLATTC by phone at 787-785-5220.

The format suggested for citation of this document is as follows:
National Hispanic and Latino ATTC. (2016). *Clinical Application of Cultural Elements for Hispanic and Latino Populations*. Bayamón, PR: Universidad Central del Caribe.

At the time of this printing Kana Enomoto, M.A., served as the SAMHSA Administrator, Kimberly A. Johnson, PhD, served as the Director of CSAT, Audra Stock, LPC, MAC, Director of Services Improvement, Sharon Amatetti, Quality Improvement and Workforce Development Branch Chief, Humberto M. Carvalho, MPH, Project Officer for CSAT and Ibis S. Carrión-González, Psy.D Director of the National Hispanic and Latino Addiction Technology Transfer Center.

The opinions expressed herein are the views of the NHLATTC and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA or CSAT. No official support or endorsement of DHHS, SAMHSA or CSAT for the opinions described in this document is intended or should be inferred.

ACKNOWLEDGEMENTS

Author
Michelle Evans, DSW, LCSW, LSOTP, CADC

National Hispanic and Latino Addiction Technology Transfer Center

Ibis S. Carrión-González, PsyD
Director
Miguel A. Cruz-Feliciano, MS, PhD
Associate Director

Staff

Digmarie A. Alicea-Santana, PhD
Darice Orobitg, PhD
Carmen Andújar-Cantres, BA
Joaquina Escudero-Texidor
Maribel González-Molina, BA

About the Author

Michelle Evans, DSW, LCSW, LSOTP, CADC

Dr. Michelle Evans is a Licensed Clinical Social Worker, Certified Alcohol and Drug Counselor, and Licensed Sex Offender Treatment Provider with experience in individual and family counseling and in developing therapeutic groups. She has worked primarily with the Latino population throughout her career as a bilingual and bicultural social worker. She is the Assistant Dean for Health Professions and Public Service at Waubonsee Community College in Sugar Grove, Illinois, and an adjunct professor and researcher at Aurora University. She also is in private practice at Nickerson & Associates, PC as a bilingual therapist where she treats adults and adolescents with mental health issues, substance abuse issues and sex addictions. Previously, she held positions within public and private psychiatric hospitals. Michelle Evans earned a Doctor of Social Work and a Master of Social Work degree from Aurora University in Aurora, Illinois.

TABLE OF CONTENTS

INTRODUCTION
The Hispanic and Latino Population: Seeking Cultural Competence

Cultural competence is a term that has been evolving for decades. It has proven to be an elusive term, as even within the most rigorous of clinical studies it is frequently defined and measured differently between researchers. Ultimately, the goal of cultural competence is to be able to conceptualize the cultural struggles that the client may be experiencing based on the norms that they may not even be aware that they have. Often, therapy may fail due to factors that are inexplicable by the provider and the client; perhaps explained by the client as "not feeling understood," or the provider feeling like they "are missing something."

Understanding cultural behaviors can be very powerful when used in treatment, as the norms and values of the family form their culturally based behaviors. These cultural issues also may define what is conflicting with the client's ability to be successful in their current environment.

Cultural competence models are not always easy to understand and adapt into a provider's conceptualization of the client's experience. One purpose of this manual is to introduce providers to a basic understanding of cultural competence and the relationship of culture to substance use disorders. In this manual, we seek to present norms and values that may impact the using and recovery experience of a person with a substance use disorder. Research demonstrates that quality of care for Hispanic and Latino individuals increases with the provider's Spanish-language proficiency and an understanding of cultural dynamics. Culturally responsive treatment may strengthen the therapeutic alliance that is necessary to increase adherence to treatment (Vega et al, 2005; Vega et al, 1999). This manual is designed to teach cultural competence concepts, values, and strategies for engagement and treatment with Hispanics and Latinos with substance use disorders.

It is very important to understand that it is not the intent of this manual to present an understanding of individuals from specific Latin American or Hispanic countries. As Hispanic and Latino individuals are so diverse in nation of origin, immigration status and experience, and level of assimilation or acculturation, this manual will present the foundational concepts to understand the norms of this population. The goal of this manual is to introduce counselors to best practices in cultural competence and to provide them with a basic knowledge to begin to integrate these concepts into their practice, and to help them develop an awareness of the impact of culture on their therapeutic work.

Will this manual provide me with everything that I need to work competently with Hispanic and Latino individuals?

Culturally competent work is a complex set of processes that requires an understanding of one's own culture, an understanding of the impact of culture on individuals and families, a foundational knowledge

base of the client's cultural norms, and a willingness to hear and understand the nuanced cultural dynamics that impact the client's problem. In the process of becoming culturally competent, the provider must be open to having his or her own beliefs and norms challenged, and he or she must convey acceptance of the client's norms. As providers are trained evaluators and assessors, withholding judgment can be challenging when the task at hand is to evaluate and develop a judgment about the situation. This manual will provide basic knowledge as to the skills and knowledge that is needed to do this successfully, however, additional experience and supervision must occur to increase a provider's ability to perform consistently in a culturally competent manner with all clients.

What does the substance use profile of Hispanic and Latino individuals look like?

The percentage of Hispanic and Latino who use substances has consistently increased within the United States over the last 12 years. The reported rate of "current illicit drug use within the last month" was 8.9% among Hispanics and Latinos 12 years of age or older in 2014 (Substance Abuse and Mental Health Services Administration, 2015). "Use of any illicit drug within the last month" increased from 7.2% in 2002, to 8.9% in 2014. "Use of marijuana in the last month" increased from 4.3% in 2002, to 6.7% in 2014. "Alcohol use within the last month" slightly increased from 42.8 in 2002, to 44.4 in 2014. Binge alcohol use remained nearly the same, as it was 24.8% in 2002, and 24.7% in 2014. Heavy alcohol use slightly decreased from 5.9% in 2002 to 5.1% in 2014 (Substance Abuse and Mental Health Services Administration, 2015).

It is evident that treatment efforts are needed, and urgently. The national Treatment Episode Data Set identified seven characteristics related to successful treatment completion in substance use treatment. These seven included being of a non-Latino White race, female, over 40, having more than 12 years of education, being employed, using alcohol as a primary substance, and having less than daily substance use (SAMHSA, 2009). When these characteristics are compared with the statistics above, it appears that culture, race, and socioeconomic factors impact treatment completion and success.

Unfortunately, this population is also often uninsured or underinsured, which can prevent access to treatment. Per the 2014 CDC National Health Interview Survey, 25.5% of Hispanic or Latino persons under the age of 65 are still without health insurance coverage, despite health care reform (CDC, 2014). This is an additional struggle to engaging this population as even when individuals access treatment, cost may be a barrier to participating and successfully completing treatment. When there are cultural barriers, such as language or congruence in treatment goals, the potential for a positive outcome of treatment lessens even more.

This manual will discuss how treatment providers can make treatment more productive with clients who frequently do not complete treatment, and that frequently feel uncomfortable in the treatment setting. Additionally, it will address the need of treatment providers to offer the foundation of culturally competent treatment as the basis of effective practice.

CHAPTER I
The Hispanic and Latino Population: An Evolving Definition
DEFINING THE POPULATION IN THE NEW MILLINEUM

What is a Hispanic or Latino individual? This term is used to collect census data, discuss race and ethnicity or migration patterns, or to describe differences between people. There is great complexity under these terms that often are not understood by individuals unfamiliar with the culture. Although individuals from Latin American and Hispanic nations such as Mexico, Puerto Rico, Spain, and Guatemala share many similar linguistic, individual, and community values, there are also great differences depending on other factors that may not be considered. These differences may include the individual's current assimilation or acculturation status, length of residence in the United States, social class, education, and life experiences of themselves or of their relatives (oppression, immigration-related separations, etc.).

What has made this definition more complex is the change in the acculturation patterns over the last 100 years. As labor mobility and population migration becomes more frequent through the ease of travel within and between countries, people are no longer identifiable by their "location of origin." Whereas it used to take three to four generations for immigrant families to fully acculturate to the United States, on average, it is now taking one to two generations. Often, members of a family may define themselves differently based on their own individual differences. For instance, a young immigrant child that is brought to the United States may define himself as a Mexican-American. As he grows up, he learns to speak English fluently without a strong accent while attending a diverse school, and he may marry someone that is non-Hispanic White. His children, who are born in the United States, may not learn Spanish. Within that family, some children may consider themselves Latino, while others may define themselves as White. Meanwhile, those children may still participate in customs of their grandparents during holidays or family gatherings, they may continue to cook and enjoy Mexican food, and they may demonstrate an adherence to Latino values. Conversely, another young immigrant child may be raised in a primarily Latino neighborhood where most of his classmates are also Latino. He may decide to raise his children speaking Spanish within a Latino neighborhood. These children may be more likely to identify themselves as Latinos. A provider that is working with either of these sets of children would be accurate in identifying both as second-generation immigrants, however, that may be where the commonalities end. The provider that is working with the parents and the children may also have to understand at least two different sets of cultural values.

Hispanic and Latinos are at a crossroads today – economically, politically, and culturally. As of 2015, Latinos are the largest ethnic minority group in the United States with 17.6% of the population defining themselves as Hispanic or Latino. For comparison, the next largest group is African American/Black at 13.3% (U.S. Census Bureau, 2016). This population is no longer concentrated in the Southwest, but is now spread across the country in small and large towns. The formerly primarily "immigrant" towns are getting smaller and more diverse as globalization occurs. Latinos are also now present in government, television, and music that is watched by individuals from many different origins. Around 35% of

Hispanic youth in 2014 entered college after high school, as opposed to 22% in 1993. However, the 66% of youth that did not attend college cited the need to help their family by entering the workforce as the primary reason that they did not continue with their education. This is an example of the cultural norm of familism impacting the advancement of the population (Pew Research Center, 2014).

This increase in visibility in the United States is creating a change in the social identity of Hispanic and Latinos, however, it may not be positive. Often, the media is promoting stigma consciousness, stereotype threat and self-fulfilling prophecy (Guyll, Madon, Prieto, & Scherr, 2010). As the mainstream media and social media continue to discuss issues of immigration in a negative way, and as stereotypical Hispanic and Latino characters are portrayed in popular media, Hispanics and Latinos continue to have their cultural identity reinforced. This can lead to internalized racism. When the stereotype of Hispanic and Latinos and substance use are considered, images of "Cheech and Chong" or stories of drug lords transporting drugs through South American countries reinforce social identities and stereotypes that cause difficulties for individuals that are attempting to recreate a personal identity that is free from substance use.

Using personal identity to understand cultural identity

Understanding cultural identity is integral to understanding the client's personal identity, their perspective of their world, and the nature of their problem. In this case, identity is used to mean the "condition or character as to who a person or what a thing is; the qualities, beliefs, etc., that distinguish or identify a person or thing" (Dictionary.com, 2016). Erik Erikson (1950) conceptualized identity as the dynamic interplay between context and the individual. This integrative conceptualization helps to provide a framework for the impact of culture on personal identity. Depending on the location where the Hispanic or Latino person lives, their socio-economic status, the presence of others like him or her, and the language and other cultural factors, the individual will result in a self-identified cohesive self that is relative to his or her environment. If the individual immigrates to a new country or otherwise changes contexts, their identity may change as their relative self-understanding changes. Schwartz, Montgomery, and Briones (2006) regarded identity "as the organization of self-understandings that define one's place in the world" (p. 5). Identity includes the personal, social, and cultural self-conceptions that guide the beliefs, values, and goals that an individual maintains. As the provider works with the individual, an understanding of how the client self-identifies and how they conceptualize their world is integral to interventions. Often, when individuals plan to integrate cultural competence into their work, they think about the client in broad terms incorporating their nationality or race. When the individual is initially considered as a person, and then as a member of larger contexts, a more accurate assessment of cultural identity can be made.

Thus, when seeking to understand the culture of the individual, understanding the context is imperative. As the individual changes contexts by moving to a different country, moving to a different socio-economic status, or by otherwise changing their group affiliation, their cultural beliefs may also change. This change is described through the concepts of assimilation and acculturation. Acculturation is defined as acquiring, maintaining, or changing cultural behaviors, values, and identities that are associated with the individual's native culture, while the culture that the individual is entering also accepts that individual and the unique perspective that the immigrant individual brings. Assimilation

refers to a one-way process in which new comers adopt the culture or standards of the dominant culture that they are entering.

As a part of the process of acculturating, the individual deals with significant stressors due to the change that they must engage in to meet the demands of the accepting culture. As the individual adopts new cultural behaviors, it can impact family relationships as members acculturate at different rates. These differences can affect acculturation outcomes, and impact whether the process is a positive or negative one. Outside of the home, the perspective of institutions and organizations on the family, and laws and social prejudices impact the psychological adaptation of the immigrant. These interfamilial and extrafamilial influences will change the perspective of the immigrant on their experience, and ultimately on their personal identity as an immigrant. These dynamics may not emerge immediately after immigration, but may continue to develop and progress as the individuals and families continue to age and mature. Especially if there have been separations between children and caregivers, there may be powerful separation and attachment issues that impact the individual's perception of self.

The impact of national origin upon cultural identity

Another element that impacts the cultural identity of Hispanic and Latino individuals is their nation of origin. National origin identities may be neglected when a provider does not acknowledge the differences of one national origin group from another. The experience of a Puerto Rican family that has recently moved to Chicago will be greatly different than a Guatemalan that immigrated 20 years ago. The national history, history of oppression and discrimination of the individual within their nation of origin, and their immigration story of a forced or voluntary immigration will impact their cultural identity. Often, a provider may incorrectly categorize an individual into a group where he or she is not a member, for instance, thinking that someone from El Salvador is from Mexico. This may be done for many reasons: the provider is unaware that there are specific differences between the nations, the provider assumes that the individual belongs to a certain national group based on their own interpretation of differences, the provider's unwillingness to consider the differences between national groups. Whatever the case, this behavior can impede cultural understandings between the provider and the client.

The term Hispanic or Latino is often used interchangeably. There are political and social inferences that are derived from these categories. Many individuals prefer to be referred to by their nation of origin, or by the term Latino. In this manual, the terms Hispanic and Latino are used to point to the commonalities shared by this group of people that is from many different nations. It is important to keep in mind the limitations of these pan-ethnic labels. Research has shown that there are some similarities within the Hispanic culture that include:

- Spirituality (*espiritualidad*);
- Dynamic social relationships (*respeto*);
- Value of personal relationships (*personalismo* and trust);
- Value of family and religion in daily life (*familismo*; Bernal et al., 2010).

However, these similarities can only be used as guidelines, as nation and personal acculturation status may impact the individual's value of these items.

The benefit of understanding and exploring cultural identity in treatment

Understanding the individual's perception of their own cultural identity provides the context to understand many of the behaviors that may seem confusing or that do not align with other observations. For instance, a client that continually returns to his group of friends, despite identifying them as a trigger and as his biggest risk factor may be battling his own value of loyalty to members of his community (social relationships). Therefore, when the provider continually challenges his behavior, he may not be able to verbalize why he cannot avoid these individuals despite the ongoing risk. Brainstorming how to manage the cultural expectations of his family and community with his need to be sobriety can be helpful, while also increasing insight into cultural beliefs and behaviors that may be reinforcing his use.

CHAPTER 2
Concepts of Culturally Competent Substance Abuse Assessment

Culturally Competent Case Formulation and Assessment

The Diagnostic and Statistical Manual, Fifth Edition (APA, 2013) has provided a cultural formulation that provides a framework for the provider to assess the culture of the individual. While culture is defined by the APA (2013) as "systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations," it is acknowledged that those cultures are "open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience." (p. 749)

Cultural competence is more than best practice; providers have an ethical necessity to develop culture-specific skills and culturally responsive interventions when working with all clients. Clinical effectiveness and cultural responsiveness are not separate proficiencies, rather, these two concepts are dependent on one another. This viewpoint allows us to understand the interaction between the cultural, political, and social contexts that explain and describe the systems and social structures that impact the client. Research demonstrates that substance use antecedents are interrelated with these dynamic systems. Latinos in the United States are more likely to experience poverty, low educational attainment, acculturation stress, and stress due to minority status (Nyamathi & Vásquez, 1995; Torres-Rivera, Wilbur, Phan, Maddux & Roberts-Wilbur, 2004). Biological models used in the West emphasize the biological "disease" model, without considering the social and family contexts that are ingrained in the understanding and cultural behaviors of Hispanic and Latino populations. This provides challenges when forming a case formulation and assessment, which, if not well understood, can compromise the entire treatment effort. A study of 107 Latino students receiving therapy from a university counseling center reported that satisfaction hinged on how well the client felt the provider understood his or her culture, not on the provider's ethnicity (Fraga, Atkinson, & Wampold, 2004). Considering that over half of Latino clients who seek mental health care terminate after just one session (Cheung, 1991), provider understanding of cultural perspectives is paramount to accurate assessment and case formulation.

Increasing the provider's ability to be culturally responsive

Cultural competence can be defined as a set of behaviors, practices, and attitudes that enable a provider to function effectively in the context of culture-related differences. Specific behaviors must be demonstrated by the culturally competent provider. The culturally responsive provider is mindful and has the skills to assess individuals from the client's environmental context without pathologizing their experiences (Gallardo & Curry, 2009). This provider also is aware of his or her own world view and how that perspective impacts his or her judgment and behavior. The provider can have an honest dialogue with the client about racial and ethnic issues, while also being able to analyze his or her own impact and influence on the conversation.

A provider must also demonstrate an awareness of culturally based schemas that he or she holds, and that the client holds. The culturally responsive provider adapts the session to accommodate those schemas. For instance, a culturally responsive provider working with a Latino immigrant adolescent that had engaged in underage drinking would encourage the client to explore issues of differences in alcohol use behaviors in his nation of origin versus the United States, recognizing that the values regarding the use of alcohol are different in each country. This understanding of context of alcohol use, for instance, can change a finding of an adolescent's deviant drinking behavior to drinking behavior that was contextually appropriate at the time.

Culturally appropriate assessment

When developing a cultural assessment, culture specific external influences must be considered. Culture specific external influences are factors related to the individual's minority status (experiences of oppression and poverty), factors related to the individual's immigration story (trauma from their home country or upon entry to the U.S.), factors related to acculturative stress (behaviors that were acceptable in their home country, such as underage drinking, are now illegal), and factors related to identity (being misunderstood, misdiagnosed, and adjusting to a new environment (Santiago-Rivera, Arredondo & Gallardo-Cooper, 2002; Sue & Sue, 2003).

Research has shown that the best assessment is completed in the individual's native language. The risks of misdiagnosis are more evident with the finding that bilingual participants who spoke Spanish as children provide more detail in Spanish than English when talking about their childhoods. This can lead to a greater expression of emotion, and a better understanding of the client by the provider (Javier, Barroso & Muqoz, 1993). As a Spanish speaking provider is not always available for every Spanish-speaking and bilingual client, non-Spanish speaking providers need to be aware of the language barrier, and must provide questions to the client with the goal of eliciting the detail needed to understand.

Assessment has been found to be more effective with Latinos who use substances when it is offered in a bilingual format (Biever et al, 2002; Santiago-Rivera & Altarriba, 2002), bicultural (Valdez, 2000), and group oriented. The assessor must understand the primary values of Hispanic and Latino cultures (such as *personalismo* or *familismo*) to understand the context of the assessment. Using a tool such as the Cultural Formulation Interview in the Diagnostic and Statistical Manual 5 (APA, 2013), providers can assess the cultural needs and context of the client. It also provides appropriate language to communicate terms previously not integrated into clinical assessment.

First (2010) proposed that the DSM-5 diagnostic process needed to meet the following objectives:

- To help providers communicate information to other practitioners, to patients and their families, and to health administrators;
- To help providers implement effective interventions to improve clinical outcomes;
- To help providers predict the future in terms of clinical management needs and likely outcomes; and
- To help providers differentiate disorder from non-disorder for the purpose of determining who might benefit from treatments (First, 2010, p. 466).

To insure those objectives were met with diverse clientele, the Cultural Formulation Interview (CFI) was developed. This interview was created specifically for the DSM-5, and was field tested at 12 sites representing several countries to determine if it was useful (Lewis-Fernández et al., 2014). This interview follows a person-centered approach to allow the interview to inform the provider as to how the client's unique world view informs their conceptualization of distress and illness. This formulation provides a multicultural world view to understand the foundation of the substance use problem. Assessment questions that help providers understand client cultural view lead to increases in patient participation throughout the interview, provider-client information exchange, interpersonal rapport, and patient satisfaction (Newes-Adeyi, Helitzer, Roter, et al., 2004; Roter, Wexler, Naragon et al., 2012; Tibaldi, Salvador-Carulla, García-Gutiérrez, 2011). With this multicultural viewpoint as offered by the CFI, the provider can then use the DSM-5 to make a culturally appropriate diagnosis, which will inform treatment planning.

The use of reliable tools can make assessment considerably easier and more accurate. This allows the provider to develop a foundational understanding which will guide the treatment interventions.

CHAPTER 3
Using Cultural Concepts of Distress to Engage the Client
Understanding the Substance Using Client

Culture impacts perception of experience. As clients are often motivated to seek treatment due to their experience of distress and suffering, an understanding of this internal experience can help providers engage substance using clients in culturally responsive ways. However, distress is relative to the perceived healthy norm. For instance, a person with a negative outlook may not perceive their mood turning into depression, while a person with a positive attitude may feel the onset of depression much more rapidly. All abnormality of mood and thought must be compared to the pathology of the culture of the individual to understand if it is a concern, or if it is a norm for that individual. Therefore, to understand cultural concepts of distress, the typical cultural values of an individual must be understood. The alliance that occurs through this mutual understanding can provide a foundation of trust, commitment, and collaboration between the provider and client.

According to the DSM-5 (APA, 2013), cultural concepts of distress are expressed three ways:

- Cultural syndromes: Groups of symptoms that co-occur among individuals in specific cultural groups, communities or contexts;
- Cultural idioms of distress: Ways that symptoms are expressed which provide a collective, shared way of experiencing and talking about personal and social concerns:
- Cultural explanations (perceived causes): Labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress (p.758).

Culture-bound syndromes describe types of illness presentations. It may be an illness without a cohesive symptom presentation, an illness with a pattern of distress in cultural settings, or an illness with diverse attributions of symptoms (England, Mysyk & Gallegos, 2007). The literature has identified several that are common within Hispanic and Latino populations, including *nervios* or nerves, *ataque de nervios* or panic attack, *susto* or fear, and *mal de ojo* or the evil eye. The translations of those terms are approximate; they all include additional features that vary from the traditional English definition. The syndrome is believed to be the dominant problem, as opposed to the experienced symptom. For instance, if, in English, we say that we have a cold, all symptoms (runny nose, congestion) are experienced as a part of that cold, and our understanding of the syndrome's origin will most likely be a disease model explanation. However, if we believe those symptoms are caused by allergies, our understanding of the syndrome's origin would likely be environmental. Understanding this syndrome based perception can help guide the provider to an understanding of the client's perspective of the origin of the illness.

Cultural idioms of distress are similar to the symptoms of an illness (for instance, congestion when you have a cold), however, the idioms include additional meaning that explains where or why the symptom is being experienced. For instance, *nervios* as a symptom may refer to a "persistent idea that is stuck."

This is more than just "being nervous", as it includes the reason, or thought process, for the nervousness. In this case, exploring the origin of the idea that is stuck and the meaning behind it could be helpful. *Coraje* (or anger) and *susto* (or fear) also may be embedded in the client's understanding of their distress. These words may also contain spiritual elements within them, depending on the client's culture.

While culture-bound syndromes and cultural idioms of distress help the provider to know what the client is experiencing, cultural explanations are harder to understand without the appropriate cultural context. Often, these explanations may be embedded in the values of the individual or family. Hispanic and Latino population often maintain the cultural values of *familismo*, *machismo*, and *personalismo* impact interpersonal and intrapersonal behaviors (Delgado, 2007). Additionally, they may prefer a greater sense of control over their illness, and may believe that physical symptoms are more serious than mental health or substance use symptoms.

The impact of acculturation on explanations of substance use

Substance use may be used as a coping mechanism to handle culture bound stressors. Initiation into substance use may occur during periods of rapid social or personal change. Historically, cultural groups who have had little exposure to a drug may not have developed protective normative behavior. Therefore, if a Hispanic or Latino individual moves from a rural area to a more urban area, the acculturative stress plus the exposure to alcohol, and other substances may have few normative protective responses to avoid use. This substance use may be understood as a way to acculturate with the environment and individuals in the new culture.

Some cultural explanations are embedded in history of the country as well; when a culture has a history of using substances, they may be more or less comfortable with frequent use. For instance, in Mexico, the drinking age is often seen as a suggestion, and often is rarely enforced. Adolescent alcohol use in the United States, then, may be seen as normal behavior and a part of the adolescent experience. A Latino individual who grew up in the United States, however, may feel that adolescent alcohol use is a risky behavior as it is illegal. The use of substances for religious ceremonies or for celebration, or to heal illnesses may also be normalized by certain countries. This cultural perspective can impact the client's response to eliminating or curtailing use.

Using culture bound explanations to engage the client

When considering the client's cultural identity, understanding the cultural reference groups, involvement with culture of origin, language, and the cultural factors of development can provide a reference point for discussion of the client's beliefs and values regarding substance use. Providing the client with non-judgmental questions will allow him to express his beliefs about the substance use, while also respecting his values regarding his use will provide a comfortable environment where the provider can then discuss how these values fit within his current context and his goals. Being attentive to the client's explanation demonstrates an interest in the client's unique culture, and it requires a non-judgmental stance on the part of the provider. Accepting those explanations as the client's truth

respects his heritage and culture, and creates an accepting environment where the client can begin to reframe his values to align with his goals.

Additionally, understanding culture bound values, such as *familismo* and *personalismo* can facilitate the engagement of the client. Recognizing the client's dedication to family (*familismo*) promotes the involvement of the family in treatment, when possible, which has been found as a protective factor. Restorative efforts to repair an individual's familial and social network can aid in prevention of recurrences. *Personalismo* can promote the use of a personal relationship within the treatment setting and between the client's support system and the provider to support the client in recovery. Cultural recovery can entail regaining a viable ethnic identity, which involves engaging with a supportive community, gaining a social role in a culturally appropriate recovering community, and acquiring a social network committed to the person's recovery. This can involve efforts by the treatment provider to help the client identify appropriate individuals that can help in the support of his recovery. Using client explanations of the problem of substance use to identify individuals and concepts to involve in treatment will lead to culturally appropriate engagement throughout the assessment and treatment process.

CHAPTER 4
Treating the Client Using a Culturally Competent Model
Planning Change and Moving Toward Action

Treating clients for substance use disorders can be challenging. The provider may conduct an appropriate culturally sensitive assessment, and he may understand the client's values and beliefs about his substance use issue, however, if the provider cannot use this formulation to create specific and meaningful goals for the client and overcome challenges as perceived by the client, often the treatment will fail or it will end treatment prematurely.

To develop a culturally appropriate treatment plan, interventions must be designed to integrate the client's concept of health, distress, and cultural values, with the framework of the provider's diagnosis, and the assessment of the provider. Research has found that interventions that are adapted for the individual's specific cultural needs (client-provider ethnic matching, services within ethnic agencies, and language appropriate services) have lowered rates of early termination (Flaskerund & Liu, 1991; Takeuchi, Sue & Yeh, 1995). Additionally, Evidence-based Practices have the highest level of success, when clients do remain in treatment.

Using culture appropriate treatments with the Hispanic and Latino population

The best approach to cultural competence is to have knowledge about specific cultures (informed by the client), with a "not knowing" stance that incorporates the cultural and personal beliefs and values of a client. Simultaneously, the provider needs to be able to recognize and respect culture-specific differences that exist due to color, class, ethnicity and gender, and identify a treatment model that will be compatible with the client's view of their illness.

Once the assessment is complete and the client has been engaged and is invested in change, a culture-informed picture of the client's understanding of their illness should be clearer. There are three primary beliefs of the origin of illness, including personalistic, naturalistic, and biomedical. Understanding these three origins of illness can help in designing interventions, especially when paired with an Evidence-Based Program that has been proven to be effective with Hispanic and Latino individuals. A complete list of evidence-based programs and practices can be found in SAMHSA's National Registry of Evidence-based Programs and Practices at http://www.nrepp.samhsa.gov.

The personalistic system of beliefs is when an individual believes that the illness is caused by the intervention of a divine being or someone with special powers. Especially with substance use issues, it can also be a belief of having bad luck. The challenge with this way of thinking is that it conflicts with most evidence based substance use treatments that require taking personal responsibility for the illness and maintaining thoughts and actions. A treatment like Acceptance and Commitment Therapy that

highlights values, metaphors based on the client's understanding, and future goals can be helpful to overcome substance use issues, while still being consistent with the personalistic system.

The naturalistic system of beliefs believes that the substance use or mental health problem stems from lack of harmony and balance. An effective evidence based treatment for Hispanic or Latino Substance users is Dialectical Behavior Therapy, for instance, as it integrates mindfulness and skills to restore balance to the individual. Additionally, many Hispanic and Latino individuals choose to use natural herbs or curanderos as an adjunctive treatment to restore overall health.

The biomedical system of beliefs is typically understood as the Western disease model. It focuses on theory, knowledge, and research of illness to advance treatment options. Cognitive Behavioral Treatment is a therapy that relies heavily on the relapse prevention techniques to avoid "relapsing" (or getting sick) again. This therapy is also an Evidence-based Practice that has been effective for use with Hispanic and Latino individuals.

Using specific frameworks to adapt treatment

There are many different models to plan for the goals and interventions needed during the intervention. The ecological validity model (Bernal, et. al, 1995) conceptualized eight dimensions of culturally relevant interventions. It was originally conceptualized for Latino populations; however, it has been researched with several other populations. Rosselló, Bernal and Rivera (2008) conducted two trials that used this model to adapt Cognitive Behavioral Therapy to include the cultural adaptations of content and methods with Puerto Rican adolescents with depression. This study found increased positive outcomes when those adaptations were used.

The ecological validity considers the following dimensions to be integral to adapt treatment models to be culturally appropriate (Bernal, et al. 2009). These dimensions include:

- Language – Both the language and words that are used;
- Persons – Individuals that the client wants in treatment, and their significance to the individual;
- Metaphors – Symbols and concepts shared by a particular group that expresses beliefs and meanings based on experiences held within that group;
- Content – Cultural knowledge about values, customs, and traditions;
- Concepts – The constructs of the theoretical model that is used in treatment. This includes the provider's conceptualization of the problem;
- Goals – The desired outcome by both the provider and the client. The goal must be congruent with the client's cultural values and belief of origin of illness;
- Methods – The procedure to follow to achieve therapeutic goals. This would also include the theory chosen;

- Context – The client's broader social, economic, and political context, including the client's understanding of themselves within the environment.

When facing a client with a unique cultural view point, the provider should consider the above dimensions of the client's understanding to identify where they might adapt cultural interventions to best meet the client's needs. The adaptation may be as simple as involving family in sessions (persons), or it may involve changing the metaphors used to understand the problem within the client's context. These frameworks plus cultural specific knowledge of the client allows the provider to provide culturally appropriate interventions.

CHAPTER 5
Understanding the Impact of Cultural Competence on the Provider

The treatment provider may be skilled at performing a culturally relevant assessment, identifying goals and appropriate treatments, however, the therapeutic relationship supports the therapeutic interventions. This relationship is not only based on the client's perspective, but also on the perspective, beliefs, and values of the provider. Cultural differences between the provider and the client may impact the client's perception of the investment of the provider in the treatment. Treatment providers often need to expand their roles to consider not just the client within the room, but also the mezzo and macro issues that impact the client's health. When we engage in a collaborative process with the client, we create a therapeutic modification by teaching our clients to problem solve and access existing internal strengths. This advocacy takes dedication from the treatment provider to treat not just the identified client, but also the context around him. There are several barriers to the engagement of the treatment provider in culturally competent work based on the internal process of the treatment provider.

Barriers to cultural competence - Communication

During the assessment and engagement phase of treatment, the culturally competent treatment provider approaches the client with an open, non-judgmental stance. However, this stance can quickly become negative if misunderstandings or miscommunication occurs. Communication between the treatment provider and the client happens verbally and non-verbally, and so often mixed messages occur when discussing issues, especially culture-based issues, that may result in erroneous inferences by either party.

Upon the initiation of the relationship, the provider must be clear as to the nature of the relationship and expectations of the provider. Also, the provider should seek out the expectations of the client to clarify any potential ethical issues or conflicts of interest. This provides the respect that will serve as the foundation of the relationship.

Barriers to cultural competence – Empathic understanding

The therapeutic relationship may be impacted by the same issues that impact interethnic relations in the large society. Treatment providers are required to face their own assumptions and stereotypes about those who are different than them in the therapeutic relationships. Comas-Díaz and Jacobsen (1991) noted that treatment providers often resolve their own ethnocultural and racial conflicts within the therapeutic relationship. The resulting ethnocultural empathy involves three elements: intellectual empathy (understanding of why the feeling is being experienced), empathic emotions, and the communication of those two elements. If any of those three elements are missing or not expressed to the client, then the client may not feel understood within the therapeutic relationship.

Barriers to cultural competence – Transference

Transference is defined as the feelings that the client has toward the provider during the therapeutic experience. A treatment provider can be non-judgmental; however, a client's previous or current experiences may cause the client to attribute unconscious thoughts and feelings toward the provider. If the provider is of the same ethnicity or race, the client may participate in an idealization of the provider as omniscient and omnipotent. Conversely, the client may feel that the treatment provider is a traitor for his success. Lastly, he may feel ambivalent toward the provider, but also fear closeness, or even have periods of hate because of auto-racism.

If the provider is of a different race, the client may present with over compliance and friendliness in an attempt not to reinforce negative stereotypes. This may also cause a denial of ethnicity and culture to avoid their own internal racial conflict, or perceived racial conflict with others. Mistrust, suspicion, and hostility can also occur, as the client may not perceive that the provider can understand her, and then behave in a hostile manner. Lastly, there may be ambivalence, as the client may have negative feelings, but may not know productive ways to discuss them or to process them (Comas-Díaz & Jacobsen, 1991).

Barriers to cultural competence – Countertransference

Countertransference is defined as "the unconscious projection of ethnic and racial prejudice onto the patient, which has a direct impact on the diagnosis and the development of the therapeutic relationship" (Quareshi, 2011. p. 1798). The intersubjective experience of the treatment provider is communicated throughout the relationship through verbal and non-verbal communication. This communication influences the relationship, and either promotes or destroys the trust needed in the therapeutic relationship. Ethnocultural countertransference involves the provider's repressed feeling as specifically related to the race of the provider and client. The goal of the provider is to be aware of his or her own biases and to explore the impact of them in supervision to avoid impacting the treatment of the client.

There may be a different experience if the client is of the same or of a different race or ethnicity of the provider. If the client is of the same race, the provider may struggle with overidentification with the client, the feeling of "us and them", distancing oneself from the client, cultural myopia, ambivalence about the client's situation, anger toward the client regarding the cultural conflict, survivor's guilt, or hope and despair regarding cultural conflict and struggle (Comas-Díaz & Jacobsen, 1991). Likewise, if the client is of a different race, the provider may deny ethnocultural difference, endorse color-blindness, or just deny that issues of ethnicity and race are important for that specific client. Conversely, the provider may appear overly interested and become a clinical anthropologist. The provider may feel guilt or pity or even aggression toward the client due to institutional racism that the client experiences. Lastly, the provider may feel ambivalence due to a lack of clarity regarding his or her own cultural experiences, and therefore the provider may struggle to recognize the client's experience.

The treatment provider's primary option to guarding against attitudes and perspectives that can impede the therapeutic relationship is to gain appropriate supervision with a supervisor that is culturally

competent and aware of the potential for ethnocultural transference and countertransference. Additionally, the treatment provider can seek to understand the cultural explanations of the client based on the application of relevant Evidenced-based Programs. Ethnocultural issues are woven into every interaction; the provider's role is to be aware of these issues, and then to seek understanding to use them as opportunities for understanding, rather than barriers to cultural competence.

CONCLUSION

Culturally competent work can be powerful in treating substance use issues within Hispanic and Latino populations. The research on this work continues to grow, but there is now sufficient evidence to show that an appropriate cultural formulation interview can provide a culturally competent assessment, which then can lead to culturally appropriate case formulations, engagement, goal setting, and interventions. The Ecological Validity Model has been empirically tested and shown to be effective in modifying Evidenced-based Programs to work with many different types of cultures. In this manual, a range of issues were presented regarding barriers and challenges confronted by the client and treatment provider in achieving a positive therapeutic alliance.

Culturally competent providers must be well trained when working with not only individuals that are different than them, but also individuals that are similar. No matter the experience level of the treatment provider, supervision must be sought in order that culturally informed biases might be confronted during the work, with the acknowledgment that cultural competence is the foundation for the therapeutic relationship.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders.* (5th Ed.). Washington, DC: Author.

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology*, 23, 67-82.199

Bernal, G., Jiménez-Chafey, M., Domenech Rodríguez, M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice*, *40*(4): 361-368. doi: 10.1037/a0016401

Bernal, G., & Sáez-Santiago, E. (2010). Culturally sensitive psychosocial interventions. *Journal of Community Psychology*, *34*(2):121-132. doi 10.1002/jcop.20096

Biever, J., Castaño, M., de las Fuentes, C., González, C., Servin-López, S., Sprowls, C., Tripp, C.G. (2002). The role of language in training psychologists to work with Hispanic clients. *Professional Psychology: Research and Practice, 33:* 330-336.

Centers for Disease Control. (2014). *FastStats. Health of Hispanic or Latino population*. Retrieved from: http://www.cdc.gov/nchs/fastats/hispanic-health.htm

Cheung, F. K. (1991). The use of mental health services by ethnic minorities. In H. F. Meyers, P. Wohlford, L .P. Guzmán, & K.J. Echemendia (Eds.), *Ethnic minority perspectives on clinical training and services in psychology* (pp. 23-31). Washington, DC: American Psychological Association.

Comas-Díaz, L., Jacobsen, F. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry, 61*(3): 392-402.

Delgado M. (2007). *Social work with Latinos: A cultural assets paradigm*. Oxford University Press; Oxford.

England, M., Mysyk, A., Gallegos, J. (2007). An examination of nervios among Mexican seasonal farm workers. *Nursing Inquiry.* 14(3). p. 189-201.

Erikson, E. (1950). *Childhood and society.* New York: Norton.

First, M. B. (2010). Clinical utility in the revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM). *Professional Psychology: Research and Practice, 41:465-473.*

Flaskerund, J., Liu, P. (1991). Effects of an Asian client-provider language, ethnicity, and gender match on utilization and outcome of therapy. *Community Mental Health Journal, 27*(1): 31–42.

Fraga, E., Atkinson, D. R., & Wampold, B. (2004). Ethnic group preferences for multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology*, *10*: 53-65.

Gallardo, M., Curry, S. (2009). Shifting perspectives: culturally responsive interventions with Latino substance abusers. *Journal of Ethnic Substance Abuse, 8*(3): 314-29. doi:10.1080/15332640903110492

Guyll, M., Madon, S., Prieto, L. and Scherr, K. C. (2010), The Potential Roles of Self-Fulfilling Prophecies, Stigma Consciousness, and Stereotype Threat in Linking Latino/a Ethnicity and Educational Outcomes. *Journal of Social Issues*, *66*: 113–130. doi:10.1111/j.1540-4560.2009.01636.x

Javier, R. A., Barroso, F., & Muqoz, M. A. (1993). Autobiographical memories in bilinguals. *Journal of Psycholinguistic Research*, *22*: 319-338.

Identity. (n.d.) *Dictionary.com Unabridged.* Retrieved from: http://www.dictionary.com/browse/identity

Kouyoumdjian, H., Zamboanga, B. L. and Hansen, D. J. (2003), Barriers to community mental health services for Latinos: Treatment considerations. *Clinical Psychology: Science and Practice*, *10*: 394–422. doi:10.1093/clipsy.bpg041

Lewis-Fernández, R., Krishan Aggarwal, N., Baarnhjelm, S., Rohlof, H., Kirmayer, L.J., Weiss, M.G., Lu, F. (2014). Culture and psychiatric evaluation: Operationalizing cultural formulation for DSM-5. *Psychiatry,* 77: 130-154. doi: 10.1521/psyc.2014.77.2.130

Newes-Adeyi G, Helitzer DL, Roter D, et al. (2004). Improving client-provider communication: evaluation of a training program for women, infants and children (WIC) professionals in New York state. *Patient Education and Counseling, 55*(2): 210–217.

Nyamathi, A., & Vásquez, R. (1995). Impact of poverty, homelessness, and drugs on Hispanic women at risk for HIV infection. In A. Padilla (Ed.), Hispanic psychology: Critical issues in theory and research (pp. 213–227). Thousand Oaks, CA: SAGE Publications.

Pew Research Center. (2014). *Fact-Tank: 5 facts about Latinos and education.* Retrieved from: http://www.pewresearch.org/fact-tank/2016/07/28/5-facts-about-latinos-and-education/ft_16-07-26_latinoseducation_collegeenrollment/

Quareshi, A. (2011). Culture and ethnicity as variable in diagnostics and therapy. *Psychiatry, 26*(1). doi: 10.1016/S0924-9338(11)73500-3

Rosselló, J., Bernal, G., Rivera-Medina, C. (2008). Individual and group CBT and IPT for Puerto Rican adolescents with depressive symptoms. *Cultural Diversity and Ethnic Minority Psychology, 14*(3): 234-245. doi: 10.1037/1099-9809.14.3.234

Roter, D., Wexler, R., Naragon, P. et al. (2012). The impact of patient and physician computer mediated communication skill training on reported communication and patient satisfaction. *Patient Education Counseling, 88*(3): 406–413.

Santiago-Rivera, A. L., Arredondo, P., & Gallardo-Cooper, M. (2002). Counseling Latinos and la familia: A practical guide. Thousand Oaks, CA: SAGE Publications.

Substance Abuse and Mental Health Services Administration. (2015). *National survey on drug use & health: Use of selected substances in the past month among persons aged 12 and over, by age, sex, race, and Hispanic origin: United States, selected years 2002-2014.* Retrieved from: http://www.cdc.gov/nchs/data/hus/2015/050.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2009). *The TEDS Report: Predictors of substance abuse treatment completion or transfer to further treatment, by service type.* Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Sue, D. W., & Sue, D. (2003). Counseling the culturally diverse: Theory and practice (4th Ed.). New York: John Wiley & Sons.

Schwartz, S., Montgomery, M., Briones, E. (2006). The role of identity in acculturation among immigrant people: Theoretical propositions, empirical questions, and applied recommendations. *Human Development, 49*: 1-30. doi: 10.1159/000090300

Takeuchi, D. T., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal of Public Health*, *85*(5): 638–643.

Tibaldi, G., Salvador-Carulla, L., García-Gutierrez, J. (2011). From treatment adherence to advanced shared decision making: new professional strategies and attitudes in mental health care. *Current Clinica; Pharmachology, 6*(2): 91–99.

Torres-Rivera, E., Wilbur, M. P., Phan, L. T., Maddux, C. D., & Roberts-Wilbur, J. (2004). Counseling Latinos with substance abuse problems. *Journal of Addictions and Offender Counseling, 25*: 26–42.

U.S. Census Bureau, Population Division. (2016). Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States and States: April 1, 2010 to July 1, 2015. Retrieved from: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

Valdez, J. (2000). Psychotherapy with bicultural Hispanic clients. *Psychotherapy: Theory, Research, Practice, Training, 37*(3): 230-246.

Vega, W., Kolody, B., Aguilar-Gaxiola, S., Catalano, R. (1999). Gaps in service utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry*, *156*: 928–934.

Vega, W., Sribney, W. (2005). Seeking care for alcohol problems: Patterns of need and treatment among Mexican-origin adults in Central California. *Alcoholism Treatment Quarterly, 23*: 29–51.

Further readings regarding treating the Hispanic and Latino population

American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist, 48*: 45-48.

Bernal, G. & Scharrón-Del-Río, M. R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. Cultural Diversity and *Ethnic Minority Psychology, 7*: 328-342.

Cuellar, I., Arnold, B., & González, G. (1995). Cognitive referents of acculturation: assessment of cultural constructs in Mexican Americans. *Journal of Community Psychology, 23*: 339-356.

Gil, A. G., Wagner, E. F., & Vega, W. A. (2000). Acculturation, familism, and alcohol use among Latino adolescent males: Longitudinal relations. Journal of Community Psychology, 28, 443-458. Institute of Medicine [IOM]. (1998). From Generation to Generation: The Health and Well-Being of Children in Immigrant Families. Washington DC: National Academy Press.

Marin, G. (1993). Influence of acculturation on familism and self-identification among Hispanics. In M. E. Bernal & G. P. Knight (Eds.), Ethnic identity: Formation among Hispanics and other minorities. New York: State University of New York Press.

Sabogal, F., Marin, G., Otero-Sabogal, R., Marín, B. V., & Perez-Stable, E. J. (1987). Hispanic Familism and Acculturation: What Changes and What Doesn't? *Hispanic Journal of Behavioral Sciences, 9*: 397-412.

Santisteban, D., Muir-Malcolm, J. A., Mitrani, V. B. & Szapocznik, J. (2002). Integrating the study of ethnic culture and family psychology intervention science. In H. Liddle, D.A. Santisteban, R. Levant, & J. Bray (Eds), Family psychology intervention science. Washington, D.C.: American Psychological Association Press.

Sue, D. W., Arrendondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*: 477-486.

Sue, D. W. & Sue, D. (2003). Counseling the culturally diverse: Theory and practice (4th ed., pp. 343-361). New York: John Wiley & Sons.

Szapocznik, J., Amaro, H., González, G., Schwartz, S. J., Castro, F. G., Bernal, G., Mora, J. & Navarro, A. (2003). Drug Abuse Treatment for Hispanics. In H. Amaro & D. E. Cortés. National strategic plan on Hispanic drug abuse research: From the molecule to the community (pp. 91-117). National Hispanic Science Network on Drug Abuse, Northeastern University Institute on Urban Health Research [funded by the Robert Wood Johnson Foundation].

Further resources on evidence-based practices for Hispanic and Latino individuals

Substance Abuse and Mental Health Services Administration (2016). National Registry of Evidence-based Programs and Practices. Retrieved from: http://www.nrepp.samhsa.gov.

NOTES

NOTES

National Hispanic and Latino ATTC
Institute of Research, Education and Services in Addiction
Universidad Central del Caribe
PO Box 60327
Bayamón, Puerto Rico 00960-6032
http://www.attcnetwork.org/hispaniclatino
hispanic@attcnetwork.org